

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6877

CERTIFICATE OF DEATH

Reg. Dist. No.

06871

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 14.03x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>9011 Grondale Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>H</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>OCT 2, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ODD JOBS</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Coffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Elsie McDanough</u> Address <u>Baltimore, 14, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced A.S.C.V. Disease</u> DUE TO (c) <u>Gastrointestinal Hemorrhage</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u> <u>10 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>6/21</u> , 19 <u>58</u> , to <u>6/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/27</u> , 19 <u>58</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>W. H. Sadowsky</u> M.D. <u>600 S. Union Ave. Harre-de-Grace, Md.</u>		DATE SIGNED <u>6/27/58</u>	
PHYSICIAN'S NAME (Type) <u>W. H. SADOWSKY</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>7-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM.</u>	
22d. LOCATION (City, town, or county) (State) <u>NORTH AVE BALTO, MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Jr</u> ADDRESS <u>6009 N. York Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Sadowsky</u>	

6894

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle May Last Banzett				4. DATE OF DEATH Month June Day 6 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 19 Hours 58 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oregon				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles C. Thomas				14. MOTHER'S MAIDEN NAME Alice Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 545-05-9678		17. INFORMANT Sibyl Hendershot, RD #1, Aberdeen, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 8 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from June 6 , 19 58 , to June 6 , 19 58 , that I last saw the deceased alive on June 6 , 19 58 , and that death occurred at 7:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6 June 1958							
ACTUAL SIGNATURE Joseph M. Silverstein M.D.				DATE SIGNED 6 June 1958			
PHYSICIAN'S NAME (Type) Joseph M. Silverstein				US Army Hospital, Aberdeen Proving Ground, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/10/1958		22c. NAME OF CEMETERY OR CREMATORY Emergreen		22d. LOCATION (City, town, or county) (State) Longport, California	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Parving				ADDRESS Aberdeen Md		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
George Thomas		Male		45		Jan 15, 1880		New England	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Crownsville		Farmer		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE	
Jan 15, 1928		10:30 AM		10:30		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF ENTRY		TIME OF ENTRY		HOURS OF ENTRY		TEMPERATURE		PULSE	
Jan 15, 1928		10:30 AM		10:30		98.6		60	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06873

6895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>MARYLAND</u> p. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD #1 BELAIR, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRYVILLE, MD</u> 07X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD CONVALESCING HOME</u>		d. STREET ADDRESS <u>SHACK ON RIVER BANK</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>BAUER</u> Last <u>BAUER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 29, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIRING BOILER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J. Bauer</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Pratt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harford Conv. Home</u>		Address <u>Beltway, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS SEVERAL YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>JUNE 15, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/19/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR <u>JUN 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
6M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6878 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Have de Grace</u>	c. LENGTH OF STAY in 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>4229 Madison St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Joseph</u> Middle <u>Bell</u> Last	4. DATE OF DEATH <u>June 1</u> 19 <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22nd</u> 1905
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATING ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>ELIZABETHTOWN, PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM S. BELL</u>		14. MOTHER'S MAIDEN NAME <u>ROUELLA CUNNINGHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>145-03-4686</u>	
17. INFORMANT <u>JAMES P. KRECKER</u>		Address <u>Riverdale, Md.</u> <u>4506 RITTENHOUSE ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> a.m. <u>6-1</u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Harford</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>6-25</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>	22d. LOCATION (City, town, or county) <u>COLUMBIA MARO R600 Co, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		ADDRESS <u>Co, Riverdale, Md.</u>	24a. REG'D BY REGISTRAR <u>JUN 4 1958</u> DATE
		24b. REGISTRAR'S SIGNATURE <u>W.D. Edlich</u>	

MEDICAL CERTIFICATION

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STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of Deceased: John Doe

2. Age: 45 Sex: Male

3. Date of Death: Jan 15, 1921

4. Place of Death: Home

5. Cause of Death: Heart Disease

6. Medical History: None

7. Signature of Examiner: John Doe

8. Signature of Coroner: John Doe

9. Signature of Physician: John Doe

10. Signature of Undertaker: John Doe

11. Signature of Burial Officer: John Doe

12. Signature of Registrar: John Doe

13. Signature of Clerk: John Doe

14. Signature of Treasurer: John Doe

15. Signature of Auditor: John Doe

16. Signature of Assessor: John Doe

17. Signature of Collector: John Doe

18. Signature of Marshal: John Doe

19. Signature of Sheriff: John Doe

20. Signature of Jailor: John Doe

21. Signature of Prisoner: John Doe

22. Signature of Warden: John Doe

23. Signature of Governor: John Doe

24. Signature of President: John Doe

25. Signature of Vice President: John Doe

26. Signature of Speaker: John Doe

27. Signature of Minority Leader: John Doe

28. Signature of Majority Leader: John Doe

29. Signature of Clerk of House: John Doe

30. Signature of Clerk of Senate: John Doe

31. Signature of Chief Justice: John Doe

32. Signature of Associate Justice: John Doe

33. Signature of Justice: John Doe

34. Signature of Attorney General: John Doe

35. Signature of Solicitor General: John Doe

36. Signature of District Attorney: John Doe

37. Signature of County Attorney: John Doe

38. Signature of City Attorney: John Doe

39. Signature of Town Attorney: John Doe

40. Signature of Village Attorney: John Doe

41. Signature of Township Attorney: John Doe

42. Signature of School Board: John Doe

43. Signature of Board of Education: John Doe

44. Signature of Board of Health: John Doe

45. Signature of Board of Public Health: John Doe

46. Signature of Board of Civil Service: John Doe

47. Signature of Board of Public Safety: John Doe

48. Signature of Board of Fire: John Doe

49. Signature of Board of Police: John Doe

50. Signature of Board of Fire and Police: John Doe

51. Signature of Board of Fire and Police and Public Health: John Doe

52. Signature of Board of Fire and Police and Public Health and Civil Service: John Doe

53. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education: John Doe

54. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health: John Doe

55. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health and Board of Public Safety: John Doe

56. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health and Board of Public Safety and Board of Fire: John Doe

57. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health and Board of Public Safety and Board of Fire and Board of Police: John Doe

58. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health and Board of Public Safety and Board of Fire and Board of Police and Board of Fire and Police: John Doe

59. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health and Board of Public Safety and Board of Fire and Board of Police and Board of Fire and Police and Board of Fire and Police and Board of Fire and Police: John Doe

60. Signature of Board of Fire and Police and Public Health and Civil Service and Board of Education and Board of Health and Board of Public Safety and Board of Fire and Board of Police and Board of Fire and Police and Board of Fire and Police and Board of Fire and Police and Board of Fire and Police: John Doe

6896 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill, Md.</u>		LENGTH OF STAY (in this place) <u>18 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Rocks Road Box 178</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ollie</u> (Middle) <u>Amos</u> (Last) <u>Campbell</u>				(Month) <u>June</u> (Day) <u>30</u> (Year) <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 7-1903</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman-Former Gas Electric Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Levi B. Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth H. Amos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>212-05-5677</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary Irene Campbell</u> <u>Forest Hill, Rocks Road Box 178</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>Epidermoid Carcinoma of Lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>prob. 1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not white <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/16/1947</u> , to <u>6/30/1958</u> , that I last saw the deceased alive on <u>6/30/1958</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Phil Barthel</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>7/1/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>July 3-1958</u>		NAME OF CEMETERY OR CREMATORY <u>Bell Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bell Air-Harford-Md</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 3 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. [Signature]</u> ADDRESS <u>Bell Air</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

AMERICAN

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO FILL THE SAME. IT IS TO BE FILED IN THE OFFICE OF THE HEALTH DEPARTMENT OF THE DISTRICT OF COLUMBIA, AND A COPY IS TO BE FURNISHED TO THE BUREAU OF VITAL STATISTICS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D. C. 20495.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

REG. NO. 100

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 10/15/1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH New York, N.Y.	
10. OCCUPATION Teacher		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. PRESENT ILLNESS Chest Pain		15. MEDICAL HISTORY None	
16. PHYSICIAN'S SIGNATURE J. Doe, M.D.		17. HOSPITAL NAME St. Mary's		18. HOSPITAL ADDRESS 123 Main St.	
19. PHYSICIAN'S ADDRESS 456 Oak St.		20. PHYSICIAN'S PHONE 123-4567		21. PHYSICIAN'S FAX 123-4567	
22. PHYSICIAN'S LICENSE 12345		23. PHYSICIAN'S SPECIALTY Internal Medicine		24. PHYSICIAN'S HOURS 9:00 AM - 5:00 PM	
25. PHYSICIAN'S SIGNATURE J. Doe, M.D.		26. PHYSICIAN'S SIGNATURE J. Doe, M.D.		27. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
28. PHYSICIAN'S SIGNATURE J. Doe, M.D.		29. PHYSICIAN'S SIGNATURE J. Doe, M.D.		30. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
31. PHYSICIAN'S SIGNATURE J. Doe, M.D.		32. PHYSICIAN'S SIGNATURE J. Doe, M.D.		33. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
34. PHYSICIAN'S SIGNATURE J. Doe, M.D.		35. PHYSICIAN'S SIGNATURE J. Doe, M.D.		36. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
37. PHYSICIAN'S SIGNATURE J. Doe, M.D.		38. PHYSICIAN'S SIGNATURE J. Doe, M.D.		39. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
40. PHYSICIAN'S SIGNATURE J. Doe, M.D.		41. PHYSICIAN'S SIGNATURE J. Doe, M.D.		42. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
43. PHYSICIAN'S SIGNATURE J. Doe, M.D.		44. PHYSICIAN'S SIGNATURE J. Doe, M.D.		45. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
46. PHYSICIAN'S SIGNATURE J. Doe, M.D.		47. PHYSICIAN'S SIGNATURE J. Doe, M.D.		48. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
49. PHYSICIAN'S SIGNATURE J. Doe, M.D.		50. PHYSICIAN'S SIGNATURE J. Doe, M.D.		51. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
52. PHYSICIAN'S SIGNATURE J. Doe, M.D.		53. PHYSICIAN'S SIGNATURE J. Doe, M.D.		54. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
55. PHYSICIAN'S SIGNATURE J. Doe, M.D.		56. PHYSICIAN'S SIGNATURE J. Doe, M.D.		57. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
58. PHYSICIAN'S SIGNATURE J. Doe, M.D.		59. PHYSICIAN'S SIGNATURE J. Doe, M.D.		60. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
61. PHYSICIAN'S SIGNATURE J. Doe, M.D.		62. PHYSICIAN'S SIGNATURE J. Doe, M.D.		63. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
64. PHYSICIAN'S SIGNATURE J. Doe, M.D.		65. PHYSICIAN'S SIGNATURE J. Doe, M.D.		66. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
67. PHYSICIAN'S SIGNATURE J. Doe, M.D.		68. PHYSICIAN'S SIGNATURE J. Doe, M.D.		69. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
70. PHYSICIAN'S SIGNATURE J. Doe, M.D.		71. PHYSICIAN'S SIGNATURE J. Doe, M.D.		72. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
73. PHYSICIAN'S SIGNATURE J. Doe, M.D.		74. PHYSICIAN'S SIGNATURE J. Doe, M.D.		75. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
76. PHYSICIAN'S SIGNATURE J. Doe, M.D.		77. PHYSICIAN'S SIGNATURE J. Doe, M.D.		78. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
79. PHYSICIAN'S SIGNATURE J. Doe, M.D.		80. PHYSICIAN'S SIGNATURE J. Doe, M.D.		81. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
82. PHYSICIAN'S SIGNATURE J. Doe, M.D.		83. PHYSICIAN'S SIGNATURE J. Doe, M.D.		84. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
85. PHYSICIAN'S SIGNATURE J. Doe, M.D.		86. PHYSICIAN'S SIGNATURE J. Doe, M.D.		87. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
88. PHYSICIAN'S SIGNATURE J. Doe, M.D.		89. PHYSICIAN'S SIGNATURE J. Doe, M.D.		90. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
91. PHYSICIAN'S SIGNATURE J. Doe, M.D.		92. PHYSICIAN'S SIGNATURE J. Doe, M.D.		93. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
94. PHYSICIAN'S SIGNATURE J. Doe, M.D.		95. PHYSICIAN'S SIGNATURE J. Doe, M.D.		96. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
97. PHYSICIAN'S SIGNATURE J. Doe, M.D.		98. PHYSICIAN'S SIGNATURE J. Doe, M.D.		99. PHYSICIAN'S SIGNATURE J. Doe, M.D.	
100. PHYSICIAN'S SIGNATURE J. Doe, M.D.		101. PHYSICIAN'S SIGNATURE J. Doe, M.D.		102. PHYSICIAN'S SIGNATURE J. Doe, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6879

CERTIFICATE OF DEATH

06876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. LENGTH OF STAY IN 1b <i>Lifetime</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harren St. Est.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Marvin</i> Middle <i>Crossell</i> Last <i>Crossell</i>				4. DATE OF DEATH Month <i>6</i> Day <i>16</i> Year <i>1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 8, 1892</i>	
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>16</i> Hours <i>19</i> Min. <i>58</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cement Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A. P. G.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Ned Crossell</i>				14. MOTHER'S MAIDEN NAME <i>Annie Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>217-052-683</i>		17. INFORMANT Address <i>Harren St. Est.</i> <i>Mrs. Clara Crossell, Harre de Grace, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Pancreas with Cholecystitis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>5/15, 1956, to 6/16, 1958</i> , that I last saw the deceased alive on <i>6/14, 1958</i> , and that death occurred at <i>6:30 A. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution St., Harre de Grace, Md.</i> DATE SIGNED <i>6/16/58</i>							
ACTUAL SIGNATURE <i>George T. Stansbury</i>							
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-19-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Berkley, Harford Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Staten St.</i> <i>Helia J. Bullock - Harre de Grace, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 19 1958</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6897 **CERTIFICATE OF DEATH**

Reg. Dist. No.

06877

1. PLACE OF DEATHCOUNTY Harford
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Edgewood R.D.,

MARYLAND

LENGTH OF STAY
(in this place)
LifetimeHOSPITAL OR
INSTITUTION OR
STREET ADDRESS**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE Maryland COUNTY HarfordCITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Edgewood, R.D.,STREET ADDRESS
(If rural give location)
Van Bibber**3. NAME OF DECEASED**
(Type or Print)

(First)

HENRY

(Middle)

F.

(Last)

DISHER**4. DATE OF DEATH**

(Month)

(Day)

(Year)

JUNE 13 1958**5. SEX**male**6. COLOR OR RACE**white**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**Widowed**8. DATE OF BIRTH**May, 26, 1885**9. AGE last birthday**73 yrs.**IF UNDER 1 YEAR**

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)Farmer**10b. KIND OF BUSINESS OR INDUSTRY**Owner**11. BIRTHPLACE (State or foreign country)**Harford Co., Maryland**12. CITIZEN OF WHAT COUNTRY?**U.S.A.**13. FATHER'S NAME**George Frederick Disher**14. MOTHER'S MAIDEN NAME**Roas M. ?**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**no

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.218-32-2598**17. INFORMANT & ADDRESS**Mrs. Mamie E. Marll, Joppa, Maryland.**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**443X IMMEDIATE CAUSE (A)CEREBRAL HEMORRHAGE

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO

HYPERTENSIVE ARTERIOSCLEROTIC

DUE TO

CARDIOVASCULAR DISEASE**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.**CONGESTIVE HEART FAILURE**INTERVAL BETWEEN ONSET AND DEATH**8 HOURSMANYYEARS5 YEARS**19a. DATE OF OPERATION**NONE**19b. MAJOR FINDINGS OF OPERATION****21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)**21a. INJURY OCCURRED While at work Not while at work****21f. HOW DID INJURY OCCUR?****22. I hereby certify that I attended the deceased from** MAY 13, 1958, **to** 13 JUNE, 1958, **that I last saw the deceased alive on** 13 JUNE, 1958, **and that death occurred at** 4:00 P.M., **from the causes and on the date stated above.****SIGNATURE**Charles W. Stewart, M.D.**ADDRESS (Street, city, town, state)**Box 95, EDGEWOOD, MD**DATE SIGNED**6/15/58**23. BURIAL, CREMATION, REMOVAL (SPECIFY)**Burial**DATE THEREOF**June, 15, 1958**NAME OF CEMETERY OR CREMATORY**Trinity Lutheran**LOCATION (City, town, or county)**Joppa, Harford, Md.**24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE**Arthur Smith**25. FUNERAL DIRECTOR'S SIGNATURE****ADDRESS**Howard R. W. Erwin, Jr. Abingdon MdDATE JUN 18 '58

INSTRUCTIONS

1 The law requires that the death certificate be executed within 24 hours after death.

2 The birth certificate may be retained by the hospital or attending physician.

3 The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEAREST RELATIVE

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CLERK

24. SIGNATURE OF DEPUTY CLERK

25. SIGNATURE OF ASSISTANT CLERK

26. SIGNATURE OF RECEPTIONIST

27. SIGNATURE OF TELEPHONE OPERATOR

28. SIGNATURE OF MAIL ROOM

29. SIGNATURE OF RECORDS SECTION

30. SIGNATURE OF IDENTIFICATION SECTION

31. SIGNATURE OF LABORATORY

32. SIGNATURE OF RADIOLOGY

33. SIGNATURE OF PATHOLOGY

34. SIGNATURE OF ANATOMY

35. SIGNATURE OF HISTOLOGY

36. SIGNATURE OF CYTOLOGY

37. SIGNATURE OF MICROBIOLOGY

38. SIGNATURE OF IMMUNOLOGY

39. SIGNATURE OF EPIDEMIOLOGY

40. SIGNATURE OF PREVENTIVE MEDICINE

41. SIGNATURE OF PUBLIC HEALTH

42. SIGNATURE OF COMMUNITY HEALTH

43. SIGNATURE OF SCHOOL HEALTH

44. SIGNATURE OF OCCUPATIONAL HEALTH

45. SIGNATURE OF ENVIRONMENTAL HEALTH

46. SIGNATURE OF FOOD SAFETY

47. SIGNATURE OF DRUG SAFETY

48. SIGNATURE OF MEDICAL EQUIPMENT

49. SIGNATURE OF HEALTH CARE

50. SIGNATURE OF HEALTH SERVICES

51. SIGNATURE OF HEALTH POLICY

52. SIGNATURE OF HEALTH RESEARCH

53. SIGNATURE OF HEALTH EDUCATION

54. SIGNATURE OF HEALTH PROMOTION

55. SIGNATURE OF HEALTH PROTECTION

56. SIGNATURE OF HEALTH CARE

57. SIGNATURE OF HEALTH SERVICES

58. SIGNATURE OF HEALTH POLICY

59. SIGNATURE OF HEALTH RESEARCH

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80. SIGNATURE OF HEALTH RESEARCH

81. SIGNATURE OF HEALTH EDUCATION

82. SIGNATURE OF HEALTH PROMOTION

83. SIGNATURE OF HEALTH PROTECTION

84. SIGNATURE OF HEALTH CARE

85. SIGNATURE OF HEALTH SERVICES

86. SIGNATURE OF HEALTH POLICY

87. SIGNATURE OF HEALTH RESEARCH

88. SIGNATURE OF HEALTH EDUCATION

89. SIGNATURE OF HEALTH PROMOTION

90. SIGNATURE OF HEALTH PROTECTION

91. SIGNATURE OF HEALTH CARE

92. SIGNATURE OF HEALTH SERVICES

93. SIGNATURE OF HEALTH POLICY

94. SIGNATURE OF HEALTH RESEARCH

95. SIGNATURE OF HEALTH EDUCATION

96. SIGNATURE OF HEALTH PROMOTION

97. SIGNATURE OF HEALTH PROTECTION

98. SIGNATURE OF HEALTH CARE

99. SIGNATURE OF HEALTH SERVICES

100. SIGNATURE OF HEALTH POLICY

101. SIGNATURE OF HEALTH RESEARCH

102. SIGNATURE OF HEALTH EDUCATION

103. SIGNATURE OF HEALTH PROMOTION

104. SIGNATURE OF HEALTH PROTECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6898

CERTIFICATE OF DEATH

Reg. Dist. No.

06878

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>				c. LENGTH OF STAY IN 1b <u>35 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROCKS OF DEER CREEK REST HOME</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>P</u> Last <u>DUFFY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 20, 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SOCIAL WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>1940-1941 TOR. City of Baltimore</u>			
13. FATHER'S NAME <u>FRANK DUFFY</u>				14. MOTHER'S MAIDEN NAME <u>BRIGID CUFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>J. H. NELSON</u>				Address <u>PERRYMAN, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PAROXYSMAL VENTRICULAR TACHYCARDIA</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>15 YRS</u> <u>OVER 10 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PAGETS DISEASES</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. <u> </u> p. <u> </u> m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>MAY 28</u> , 19 <u>58</u> , to <u>JUNE 29</u> 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 22</u> , 19 <u>58</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Heuman</u>				M.D. <u>307 HICKORY</u>		DATE SIGNED <u>JUNE 29, 58</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN MD</u>				ADDRESS (Street, city or town, state) <u>BEL AIR, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Meeks</u>				ADDRESS <u>205 N. Calvert St.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. W. Meeks</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		TIME OF BIRTH [Faint handwritten time]	
PLACE OF DEATH [Faint handwritten place]		DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	
DISTRICT [Faint handwritten district]		WARD [Faint handwritten ward]		BLOCK [Faint handwritten block]	
HOUSE NO. [Faint handwritten house no.]		STREET [Faint handwritten street]		CITY [Faint handwritten city]	
COUNTY [Faint handwritten county]		STATE [Faint handwritten state]		ZIP CODE [Faint handwritten zip code]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film 231 7-15-58 et
6899
CERTIFICATE OF DEATH

06879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
		d. STREET ADDRESS 1	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Paul Last Flottesch		4. DATE OF DEATH Month June, Day 18 Year 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 26, 1911
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 16 Hours 45 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Dairy Farmer	
11. BIRTHPLACE (State or foreign country) Joppa, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Flottesch		14. MOTHER'S MAIDEN NAME Mary E. Dwaayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-36-7947	
17. INFORMANT Henry J. Flottesch		Address Joppa, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1958 to June 17, 1958 , that I last saw the deceased alive on July 17, 1958 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jed O. Hodous		ADDRESS (Street, city or town, state) Edgewood Md DATE SIGNED 6-18-58	
PHYSICIAN'S NAME (Type) F. O. Hodous			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Stephen's		22d. LOCATION (City, town, or county) (State) Bradshaw, Balto. Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward K. McConough		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
ADDRESS Abingdon, Md.		24b. REGISTRAR'S SIGNATURE W. H. Beach	

6880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>16 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>			d. STREET ADDRESS <u>1204 PA. AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>CORNELL</u> Last <u>Flynn</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) <u>3</u> yrs. <u>6</u> Moths <u>6</u> Days <u>6</u> Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Milton Flynn</u>			14. MOTHER'S MAIDEN NAME <u>Ina Cornell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hosp Records, Har de Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fulminating pneumonia</u> DUE TO (c) <u>20 hours</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Croup</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u>	
20f. (City or town) <u>?</u>		20g. (County) <u>?</u>		20h. (State) <u>?</u>	
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>58</u> , to <u>6/12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>58</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Har de Grace Md</u> DATE SIGNED <u>Theodore H. Gavier M.D.</u>					
ACTUAL SIGNATURE <u>Theodore H. Gavier M.D.</u>					
PHYSICIAN'S NAME (Type) <u>Theodore H. Gavier M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/16/58</u>		22b. DATE THEREOF <u>6/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Harford Mem. Park, Richmond, Va.</u>	
22d. LOCATION (City, town, or county) <u>Richmond, Va.</u>		22e. (State) <u>?</u>		22f. (County) <u>?</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Prugh R. R. Har de Grace Md</u>		23a. REC'D BY REGISTRAR <u>?</u>		23b. REGISTRAR'S SIGNATURE <u>?</u>	
23c. ADDRESS <u>Har de Grace Md</u>		23d. DATE <u>JUN 17 '58</u>		23e. (State) <u>?</u>	

MEDICAL CERTIFICATION

1
B
M
71
I

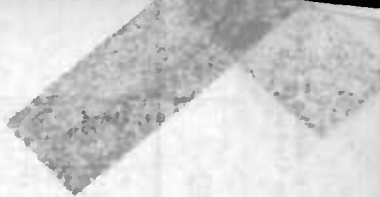
THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PAGE 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED OUT, PAGE 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

Form 1

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Date of registration		14. Registrar's office	
JAMES EARL RAY		Male		White		May 19, 1928		Memphis, Tennessee		2814 1/2 West Baltimore Ave., Baltimore, Md.		April 4, 1968		Baltimore, Md.		Suicide		Homicide		[Signature]		[Signature]		April 11, 1968		Baltimore, Md.	
15. Date of funeral		16. Place of funeral		17. Name of funeral home		18. Name of officiating clergyman		19. Name of undertaker		20. Name of cemetery		21. Name of burial place		22. Name of interment place		23. Name of crematorium		24. Name of crematory		25. Name of cremator		26. Name of cremator		27. Name of cremator		28. Name of cremator	
April 11, 1968		Baltimore, Md.		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]	



1 1 50 1 12 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6900

CERTIFICATE OF DEATH

06881

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Michigan b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USAH, A.P.G. MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAY CITY 59X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S.A.H.A.P.G. MD.		d. STREET ADDRESS 320 NEBORISH	
3. NAME OF DECEASED (Type or print) First RICHARD Middle H. Last GEISZ		4. DATE OF DEATH Month JUNE Day 8 Year 19 58	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4 1940
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNITED STATES NAVY		10b. KIND OF BUSINESS OR INDUSTRY US Navy	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY GEISZ		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) PRESENT TIME		16. SOCIAL SECURITY NO. 372-38-8532	
17. INFORMANT Official Naval Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X CEREBRAL CONTUSION, RT. TEMPORAL LOBE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COMPOUND, COMMUNUTED FRACTURE, RT. TEMPORAL LOBE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTOMOBILE ACCIDENT PASSENGER OF AUTO WHICH RAN INTO BACK OF TK	
20c. TIME OF INJURY Month, Day, Year Hour o. m. X p. m. JUNE 7 19 58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PAIASKI HWY. (40) JOPPA		20f. (City or town) (County) (State) Harf. MD.	
21. I certify that I attended the deceased from 0500 HRS. , 19 58 , to 8 JUNE , 19 58 , that I last saw the deceased alive on 8 JUNE , 19 58 , and that death occurred at 1:45 PM , from the causes and on the date stated above. D.S. ADDRESS (Street, city or town, state) U.S.A.H.A.P.G. MD. 8 JUNE 58 DATE SIGNED			
ACTUAL SIGNATURE Charles C. Weise M.D.		PHYSICIAN'S NAME (Type) CHARLES C. WEISE, CAPT. MC	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Removal & Burial 6-11-58		22d. LOCATION (City, town, or county) (State) Bay City, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Lee G. Patterson & Son ADDRESS Perryville, Md		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

CERTIFICATE OF DEATH

FILE NO. 100

DATE OF DEATH
1912

PLACE OF DEATH
BALTIMORE

CAUSE OF DEATH
DIPHTHERIA

AGE
10

SEX
MALE

EDUCATION
SCHOOL

OCCUPATION
NONE

RELIGION
METHODIST

DATE OF BIRTH
1902

PLACE OF BIRTH
BALTIMORE

CAUSE OF DEATH
DIPHTHERIA

AGE
10

SEX
MALE

EDUCATION
SCHOOL

OCCUPATION
NONE

RELIGION
METHODIST

DATE OF BIRTH
1902

PLACE OF BIRTH
BALTIMORE

CAUSE OF DEATH
DIPHTHERIA

AGE
10

SEX
MALE

EDUCATION
SCHOOL

OCCUPATION
NONE

DR. J. H. HARRIS

DR. J. H. HARRIS

DR. J. H. HARRIS

DR. J. H. HARRIS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George</i> First <i>Wm.</i> Middle <i>Glassman</i> Last		4. DATE OF DEATH Month <i>6</i> Day <i>3</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/2/1897</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Glassman</i>		14. MOTHER'S MAIDEN NAME <i>Marie Whitte</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>220-36-800</i>	
17. INFORMANT <i>David Glassman</i>		Address <i>North East. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive C V disease</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>6 months</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>12</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 15, 1958</i> to <i>June 3, 1958</i> , that I last saw the deceased alive on <i>June 1, 1958</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		ADDRESS (Street, city or town, state) <i>Bethesda Md.</i> DATE SIGNED <i>6-5-58</i>	
PHYSICIAN'S NAME (Type) <i>Gerald C Palmer M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/6/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Paul Lutheran</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Sarriving</i> ADDRESS <i>Aberdeen Md</i>		24a. REC'D BY REGISTRAR <i>June 9 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Adrian</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel-air</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel-air</i>			
c. LENGTH OF STAY IN 1b <i>Lifetime</i>				d. STREET ADDRESS <i>R. F. D. #1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R. F. D. #1</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Henry</i> Last <i>Hill</i>				4. DATE OF DEATH Month <i>6</i> Day <i>18</i> Year <i>1958</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 12, 1917</i>	
9. AGE (In years last birthday) <i>40</i> yrs.		10. IF UNDER 1 YEAR Months <i>40</i> Days <i>18</i> Hours <i>19</i> Min.		11. BIRTHPLACE (State or foreign country) <i>Bel-air, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>			
13. FATHER'S NAME <i>Augustus Hill</i>				14. MOTHER'S MAIDEN NAME <i>Laura V. Wilson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Mrs. Helen Rice, Bel-air, Md.</i>				Address <i>R. F. D. #1 Bel-air, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 7444.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Muscular Dystrophy</i> DUE TO (c) <i>Muscular Dystrophy</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>6/9</i> , 19 <i>58</i> , to <i>6/18</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/17</i> , 19 <i>58</i> , and that death occurred at <i>8:30 P. M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>George T. Stansbury</i>				ADDRESS (Street, city or town, state) <i>569 Revolution St., Harford Co., Md.</i>			
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				DATE SIGNED <i>6/20/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6-21-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Clarks Chapel Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Palmer, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William S. Buellock, Harford Co., Md.</i>				ADDRESS <i>Harford Co., Md.</i>			
24a. REC'D BY REGISTRAR <i>JUN 24 '58</i>				24b. REGISTRAR'S SIGNATURE <i>W. L. Beach</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Maurice</i> Middle <i>Holloway</i> Last <i>Holloway</i>		4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/30/1876</i>
9. AGE (In years last birthday) yrs. <i>81</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Chas. R. Holloway</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Gallup</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes and, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Wife - 449 W Bel Air Ave Aberdeen Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>5-6 yrs</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 26</i> , 1957, to <i>June 15</i> , 1958, that I last saw the deceased alive on <i>June 15</i> , 1958, and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i>		ADDRESS (Street, city or town, state) <i>617 W. Belair Ave Aberdeen, Md.</i>	
PHYSICIAN'S NAME (Type) <i>B. J. Plunkett Jr. M.D.</i>		DATE SIGNED <i>6-15-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6/17/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Spesutia</i>	22d. LOCATION (City, town, or county) (State) <i>Perryman Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Garrison</i>		ADDRESS <i>Aberdeen Md</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 19 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Abraham</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Farm Chas Vace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert Luther Joines</u>		4. DATE OF DEATH <u>June 5 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18, 1933</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		11. BIRTHPLACE (State or foreign country) <u>Hickory, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>KYLE JOINES</u>	
14. MOTHER'S MAIDEN NAME <u>PAULETTE OSBORNE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>164-28-6904</u>		17. INFORMANT <u>Mr. Jean Joines</u> Address <u>Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Abdominal Injuries</u> <u>835X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture L. hip</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture L. hip</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>He parked truck, it ran away, he tried to stop it</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:10 a.m. 6-8-58</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm Chas Vace</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED <u>6-5-58</u>	
EXAMINER'S NAME (Type) <u>Ronald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GUINSTON UNITED PRESBY.</u>		22d. LOCATION (City, town, or county) <u>CHANCEFORD TWP, YORK Co., Pa.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Durham</u> ADDRESS <u>Stewartstown, Pa.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
RECORD

[Faint, mostly illegible text and markings on the form, including checkboxes and handwritten notes.]

NOTED TO
FILE



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06886

6883

Item 8 Film G230 7-1-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>111 N. Bond St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 N. Bond St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY Middle E Jones</u>		4. DATE OF DEATH <u>June 20</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890</u> <u>June 27-11891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wilkinson Dr</u>	
11. BIRTHPLACE (State or foreign country) <u>45</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Banji Hackett</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hanson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>68742 English</u>	
17. INFORMANT <u>111 N. Bond St Bel Air Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>slotting the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>6-20-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa 22 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Latta Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>W. J. Smith</u> DATE <u>JUN 24 '58</u>	
24b. REGISTRAR'S SIGNATURE			

STATE DEPT
JAN 21 1961

RECEIVED
JAN 21 1961
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20540

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: John A. Jones

2. SEX: Male

3. AGE: 45

4. DATE OF DEATH: Jan 18, 1961

5. TIME OF DEATH: 10:15 AM

6. PLACE OF DEATH: Home

7. OCCUPATION: Engineer

8. CAUSE OF DEATH: Myocardial Infarction

9. MANNER OF DEATH: Natural

10. SIGNATURE OF MEDICAL EXAMINER: [Signature]

11. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

12. SIGNATURE OF CORONER: [Signature]

13. SIGNATURE OF JURY: [Signature]

14. SIGNATURE OF WITNESSES: [Signature]

15. SIGNATURE OF DECEASED: [Signature]

16. SIGNATURE OF NEXT OF KIN: [Signature]

17. SIGNATURE OF BURIAL OFFICIAL: [Signature]

18. SIGNATURE OF FUNERAL HOME: [Signature]

19. SIGNATURE OF CEMETERY: [Signature]

20. SIGNATURE OF STATE DEPARTMENT OF HEALTH: [Signature]

CERTIFICATE OF DEATH

06887

Reg. Dist. No.

6884

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hammond Chase</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>ELDORA</u> Middle <u>MCCARTHY</u> Last		4. DATE OF DEATH <u>6/4/58</u> Month <u>6</u> Day <u>4</u> Year <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 13, 1862</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>ESSEX CENTER VT.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John PEPIN</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>not</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Benedictine McCarthy</u> Address <u>314 N. Union</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 599X DUE TO <u>Transition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Failure</u> DUE TO (c) <u>Terminal</u> 10 da. 2 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23-1958</u> to <u>6-4-1958</u> , that I last saw the deceased alive on <u>6-3-1958</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>8 Low St. Aberdeen, Md.</u> DATE SIGNED <u>6-5-58</u>	
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/9/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's</u>		22d. LOCATION (City, town, or county) (State) <u>Howell Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony P. Hammond</u>		24a. REC'D BY REGISTRAR <u>June 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

CE 111 10 2 10

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>M</i>	RACE <i>W</i>
DATE OF DEATH <i>10/15/53</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>	CAUSE OF DEATH <i>Heart Disease</i>
DISEASE OR INJURY <i>Myocardial Infarction</i>		PERIOD OF ILLNESS <i>2 weeks</i>	PREVIOUS ILLNESS <i>None</i>	PREVIOUS SURGERY <i>None</i>
SIGNS AND SYMPTOMS <i>Shortness of breath, chest pain</i>		DIAGNOSIS <i>Myocardial Infarction</i>	TESTS <i>ECG, X-ray</i>	TREATMENT <i>Aspirin, Morphine</i>
PHYSICIAN'S SIGNATURE <i>[Signature]</i>		HOSPITAL <i>None</i>	ATTENDING PHYSICIAN <i>[Signature]</i>	PATHOLOGIST <i>[Signature]</i>
MUNICIPALITY <i>Baltimore</i>		COUNTY <i>Harford</i>	STATE <i>MD</i>	ZIP CODE <i>21040</i>

6885

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle A Last NEFF		4. DATE OF DEATH Month JUNE Day 9 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 5 IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. 5
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Malcolm Earl Neff		14. MOTHER'S MAIDEN NAME Shirley Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. Malcolm E. Neff		18. ADDRESS Post #39 Legion Apt. House BEL AIR, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/6 , 19 58 , to 6/9 , 19 58 , that I last saw the deceased alive on 6/9 , 19 58 , and that death occurred at 4:00 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodore H. Kauer		M.D. —	
PHYSICIAN'S NAME (Type) —			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 10, 1958	22c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS	22d. LOCATION (City, town, or county) (State) BEL AIR, Harford Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		ADDRESS Broadway + Williams St BEL AIR, Maryland	
24a. REC'D BY REGISTRAR JUN 11 '58		24b. REGISTRAR'S SIGNATURE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6886 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>		c. LENGTH OF STAY IN 1b <u>3 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aberdeen Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>HARRY</u> Middle <u>OSBORNE</u> Last			4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/58</u>	9. AGE (in years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>Hynd Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Alfred Harris</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Osborne</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Margaret Osborne</u> Address <u>Aberdeen RD Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>767.0</u> DUE TO (b) <u>Chronic Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Infection of Umbilical Cord</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William V. Gortch</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial June 30, 1958</u>			22b. DATE THEREOF		
22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's</u>			22d. LOCATION (City, town, or county) <u>Hynd Co. Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. McCombs Jr.</u>			24a. REC'D BY REGISTRAR <u>Abingdon</u>		
24b. REGISTRAR'S SIGNATURE <u>Abingdon</u>			DATE <u>June 3 '58</u>		

DATE SIGNED

June 29 1958

201181XV2

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH ONE 18
1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1900 STATE
HEALTH OFFICE

[Faint, mostly illegible handwritten text and form fields. Visible fragments include:]

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DIAGNOSIS
SIGNATURE OF EXAMINER
DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06890

6887

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Emery</u> Last <u>Purham</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired A.P.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlottesville, W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emory Purham</u>		14. MOTHER'S MAIDEN NAME <u>Phenice Purham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emery Purham</u>		Address <u>134 Devere ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis with</u> <u>420.1</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 30th 1958</u> to <u>June 27th 1958</u> that I last saw the deceased alive on <u>June 27th 1958</u> and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harre-de-Grace, Md.</u>	
DATE SIGNED <u>6/27/58</u>		PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>6/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR DATE <u>JUL 3 '58</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6902

CERTIFICATE OF DEATH

Reg. Dist. No. 06891

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cardiff</u>	c. LENGTH OF STAY IN 1b <u>40 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cardiff</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Stanley Ramsey</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1978</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28-1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	11. BIRTHPLACE (State or foreign country) <u>Jarrettsville</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm Ramsey</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Street</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Laura Ramsey Cardiff road.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>hypertensive cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 3, 1978</u> to <u>June 3, 1978</u> that I last saw the deceased alive on <u>June 20, 1978</u> , and that death occurred at <u>6:30 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>BENJAMIN DOROGI, M.D.</u>		DATE SIGNED <u>6/13/78</u>	
PHYSICIAN'S NAME (Type) <u>Cardiff, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 5-78</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>	22d. LOCATION (City, town, or county) (State) <u>Madonna Hartford MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skirby Jarrettsville road</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '78</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Thomas Jones		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1880		5. PLACE OF BIRTH St. Louis, Mo.		6. OCCUPATION Teacher	
7. DATE OF DEATH Dec 10, 1925		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Myocardial Infarction		12. MEDICAL HISTORY None	
13. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		14. SIGNATURE OF WITNESSES John Doe, Jane Doe		15. SIGNATURE OF DECEASED John Thomas Jones		16. SIGNATURE OF FUNERAL HOME None		17. SIGNATURE OF BURIAL PLACE None		18. SIGNATURE OF REGISTRAR None	
19. NAME OF FUNERAL HOME None		20. NAME OF BURIAL PLACE None		21. NAME OF REGISTRAR None		22. NAME OF PHYSICIAN Dr. J. H. Smith		23. NAME OF WITNESSES John Doe, Jane Doe		24. NAME OF DECEASED John Thomas Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6888

CERTIFICATE OF DEATH

06892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air 32</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hertude</u> Middle <u>Mary</u> Last <u>Roloson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 - 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Roloson</u>				14. MOTHER'S MAIDEN NAME <u>Frances Cash</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Albert S Roloson</u> Address <u>Bel Air MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260x</u> (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO <u>Disease</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Diabetes mellitus ② Fracture of left hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 16th</u> , 19 <u>58</u> to <u>June 17th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 17th</u> , 19 <u>58</u> , and that death occurred at <u>11:47 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>6/17/58</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, MD</u>				<u>Harford de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FRIENDS BURIAL GROUNDS</u>		22d. LOCATION (City, town, or county) (State) <u>2506 HARFORD RD BRITAIN, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Fatur</u> ADDRESS <u>W. Broadway + Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6903

CERTIFICATE OF DEATH

06893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Susan Last Sliver			4. DATE OF DEATH Month June Day 10 Year 1958				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1866		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (State or foreign country) York Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Sliver			14. MOTHER'S MAIDEN NAME Rachel Ann Norris				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Hugh P. Jones, Whiteford, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 days. years not known.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 56 , to 10 June , 19 58 , that I last saw the deceased alive on 5 JUNE , 19 58 , and that death occurred at 3:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thos. A. E. Moseley Jr. M.D. JARRETTSVILLE, Md. 10 JUNE 1958 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Thos. A. E. MOSELEY, Jr. M.D. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Fawn Twp., York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins				ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

CERTIFICATE OF DEATH

Page No. 14

County

Age

Sex

Married

Place of Birth

Occupation

Usual Residence

Date

Time

Place

Cause

Manner

Signature

Physician

Medical History

History of Present Illness

Post Mortem

Remarks

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Health Officer

Signature of County Health Officer

Signature of State Health Officer

Signature of State Health Officer

Signature of State Health Officer

Signature of State Health Officer

Signature of State Health Officer

Signature of State Health Officer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06894

6904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	c. LENGTH OF STAY IN 1b <u>18 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>		d. STREET ADDRESS <u>RD 2 Box 287</u>	
3. NAME OF DECEASED (Type or print) <u>Archie L Thorpe</u>		4. DATE OF DEATH <u>June 22 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1919</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Buses</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Benjamin L. Thorpe</u>	
14. MOTHER'S MAIDEN NAME <u>Dora Thornton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-10-9658</u>		17. INFORMANT <u>Florence V. Thorpe</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GSW Cerebrum</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-22-58</u> Hour <u>2:30</u> p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Bel Air Hartford md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Derald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>6-22-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR <u>JUN 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlebach</u>			

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51-10557-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06895

6889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>	c. LENGTH OF STAY IN 1b <u>20 HRS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 ABERDEEN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>BALTIMORE ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>TOLIVER</u> Last <u>TOLIVER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1958</u>
9. AGE (In years lost birthday) yrs. <u>20</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>20</u> Days <u>31</u> Hour <u>31</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN A. TOLIVER</u>	
14. MOTHER'S MAIDEN NAME <u>ADA HIGGINS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hyaline Membrane</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/13</u> , 19 <u>58</u> , to <u>6/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>58</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>569 Revolution St. Haure de Grace, Md.</u> DATE SIGNED <u>6/14/58</u> ACTUAL SIGNATURE <u>George T. Stensbury, M.D.</u> PHYSICIAN'S NAME (Type) <u>George T. Stensbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Haure de Grace, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hugh J. administrator</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Seduck</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		1900		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
Physician		Heart Disease		Natural		Home		1945	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. COUNTY		17. CITY		18. STATE		19. ZIP CODE		20. OTHER	
Baltimore		Baltimore		Maryland		21201			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6890

CERTIFICATE OF DEATH

06896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Tarlington Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Tarlington Md.</u> d. STREET ADDRESS <u>Near Tarlington Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Elizabeth</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>6</u> Day <u>26th</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nicholas P. Evans</u>		14. MOTHER'S M maiden NAME <u>Lena Heidrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Wm. H. Watt (daughter)</u>		Address <u>1.2nd. Hartford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart dis.</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u> <u>4 yr.</u> <u>4 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Phlebotrombosis, left leg - 10 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1958</u> to <u>6-26-1958</u> , that I last saw the deceased alive on <u>6-25-1958</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u> DATE SIGNED <u>6-26-58</u>			
ACTUAL SIGNATURE <u>Peter P. Rodman</u>		M.D. <u>Peter P. Rodman, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		ADDRESS <u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Somerville New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Darrington</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jul 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Abraham</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

HABIT

PLACE OF BIRTH

AGE

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

PLACE OF REINTERMENT

FILE NO. 8/30/38

6891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 Rogers Street		d. STREET ADDRESS 229 Rogers Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank Loney Wight		4. DATE OF DEATH Month June Day 28 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Aug. 1886
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distiller		10b. KIND OF BUSINESS OR INDUSTRY Whisky Distillery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John H. Wight		14. MOTHER'S MAIDEN NAME Esther Loney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ann Wight		Address 229 Rogers St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) Arteriosclerosis heart disease DUE TO (c) Coronary arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 yr. 2 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Empyema, right pleural space, possibly due to carcinoma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 53 , 19 53 , to 6-28-58 , 19 58 , that I last saw the deceased alive on 6-28-58 , and that death occurred at 3:45 am from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 6-30-58			
ACTUAL SIGNATURE Peter P. Rodman M.D.		DATE SIGNED 6-30-58	
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/58	
22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR JUL 2 58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6892

CERTIFICATE OF DEATH

Reg. Dist. No.

06898

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hartford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre De Grace</i>				c. LENGTH OF STAY IN 1b <i>6-9 to 6-29</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Street (Rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Hartford Memorial Hospital</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Esther Virginia Wilson</i>				4. DATE OF DEATH Month <i>June</i> Day <i>29</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/21/24</i>	
9. AGE (In years last birthday) <i>34</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>George Glassman</i>				14. MOTHER'S MAIDEN NAME <i>Zollie Grace</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>217-16-6637</i>		17. INFORMANT <i>Hus Band</i> Address <i>Street, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pyelonephritis</i> <i>600.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <i>June 29</i> , 19 <i>58</i> , and that death occurred at <i>12:30 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>608 South Union, Harre De Grace</i> DATE SIGNED <i>6-29-58</i>							
ACTUAL SIGNATURE <i>Frank D. Hauber</i> M.D.				PHYSICIAN'S NAME (Type) <i>Frank D. Hauber M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/2/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		22d. LOCATION (City, town, or county) (State) <i>Bel Air, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Larring</i> ADDRESS <i>Aberdeen, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

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